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Remarks of
HENRY A. WAXMAN,
Chairman,
Subcommittee on Health and the Environment
before
The Group Health Institute
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On the Government's Role in an Age of Increasing Competition

I'm glad to be with you today.

I've been asked to talk about the "Role of Government in an Age of Increasing Competition." First I'd like to beg the question for a moment and be sure that we're all talking about the same thing.

Competition in health today means the same thing as competition in automobiles or VCR's or missiles: Competition is the simple effort to draw dollars from one segment of the economy to another. It is your attempt to convince people to buy more health instead of more entertainment or more real estate.

Within the health care industry itself, the same sort of competition appears in a microcosm: Providers advertise new products or cut prices or improve quality to get a larger market share.

We can easily see the price competition between hospitals. We can watch the capitation rates of HMO's versus those of CMP's. We can see large employers shopping around for package deals, and we can see government looking for any way to save money--without caring if its fair share of costs is shifted to others.

This is the "increasing competition" of the Eighties, and it makes mistakes in paying for health care.

For you this competition is for the consumer's health dollar. And that competition will occur in an environment of multiple forms of government regulation: State licensure and insurance laws, PRO's, health planning (or whatever resource allocation mechanism replaces it), controls on reimbursement by Medicare and Medicaid, and antitrust laws.

It also will occur in a new era of tight federal budget controls. If the Gramm-Rudman legislation passes its constitutional challenge, the government's ability to participate in the purchase of health care will be profoundly affected.

Competition in health care in the Eighties is not the "free market" of the Reagan Administration's rhetoric. Although the Administration speaks of the "de-regulation" of health care, it has brought us anything but. Medicaid cuts, DRG's, and hospital and physician fee freezes are more intrusive intervention in the market than any of the planning or review agencies of the previous twenty years.

But those who talk of an unfettered marketplace argue that this competition will lead to the "right" distribution of goods and services. The invisible hand of the market is supposed to do the work of deciding both what is efficient and what is good.

But in health care this argument runs head on into America's self-image. Americans have expectations of basic rights: food, shelter, health care. I believe that Americans expect these things for themselves, and I believe that we expect them for our fellow citizens.

Unlike people in medieval Europe or England before Dickens, most Americans do not accept their country as a place for hunger, homelessness, and disease. If we did, the Reagan Administration could candidly pursue its agenda of ending compassion for the sick and the poor, rather than trying to camouflage it as a pursuit of efficiency.

But even the Reagan Revolution cannot end the Nation's belief in basic care.

Americans who may think that competition is the right way to decide whether IBM or Apple will control the computer market do not accept the competitive result for health.

Most of us are unwilling to live in a society that is survival of the fittest for sick children.

Few voters support the notion that the frail elderly should fend for themselves.

The competitive marketplace for health care does not produce the result Americans want. Government must intervene because this market is for healthy people with money. The competition does not extend to sick people with none.

I want to focus on this issue of equity, because I believe it is the single greatest health problem facing the federal government in this age of increasing competition and federal budget constraints.

The market, that has served us well in so many areas of economic development, fails to help us with the poor and the uninsured. Until World War II, Americans lived with this market failure as an unchangeable reality.

Medical policy did not heed the words of John Stuart Mill, who began an economic revolution in the Nineteenth Century by pointing out that "the distribution of wealth depends on the laws and customs of society," and that "the rules by which it is determined are what the opinions and feelings of the ruling portion of the community make them."

To some extent, Mill's argument against "natural economics" began government by incentives and regulations and subsidies and tax.

Without such arguments, the poverty of the industrial revolution might have continued as the way of life. Such market failures as worker safety and child labor might never have been addressed.

It has taken a long time for Americans to realize that the failure of supply and demand to provide health care for the poor can be corrected also, and that the distribution of the wealth of medical services can and should be adjusted.

The role of government has been to make the health care market work for all people.

At one time, some of the poor and uninsured were helped by simple charity. While many people just went without, hospitals and doctors took care of some without expecting fees. The costs of providing such care was often just built into the charges to those patients who could pay.

Then Federal and State aid began. Medicare was to care for the elderly. Medicaid was to address the basic needs of many of the poor. And whatever charity care was still provided was built into the indirect costs of hospitals and still subsidized by those who could pay, including Medicare.

Then competition came into health. Prepaid plans provide more generous services at a lower monthly rate. Employers have begun to use their sizable market power to shop for hospitals and insurers who cost less. And the Medicare program has squeezed down on how much it will pay to providers, freezing fees and setting DRG's at a level insufficient to allow all costs, and certainly not enough to provide subsidies of uncompensated care.

At the same time that competition got its start, the Federal government also began to renege on its promises to correct the market. The elderly now use proportionately more of their income for health services than they did before Medicare was enacted. Medicaid's payment for the poor has been made so painfully inadequate that few providers will serve them.

The result is that the number of people with no coverage and with inadequate coverage continues to grow. I do not believe that most Americans support this result. Only a few people would argue now for bringing back the "county home" for the elderly or the charity wards for the sick.

I am concerned that as this competition continues, the market may become so fragmented that risk-sharing will disappear. The risk pool that once contained young and old and healthy and sick may be skimmed several times. And those left in the pool will find no one willing to care for them, certainly not at a price they can afford.

This issue is a challenge for the federal government and for you. Fewer than one out of four Federally qualified HMO's have enrolled any Medicaid patients.

While we want quality HMO's to enroll Medicaid beneficiaries, we all have a responsibility to guard against pre-paid plans that are set up to serve only the poor or the Medicare-eligible, plans that may take advantage or the relative vulnerability of public patients and skimp on the quality of care provided.

For years now, the Federal government has paved the way for your industry to grow and mature. We have prohibited anti-competitive regulation by States. We have mandated dual choice. We have set levels of employer contribution. We have promoted Medicare participation in HMO's and provided a reimbursement level of 95 percent of the average Medicare payment.

Your growth has been extraordinary. In 1984, enrollment grew by twenty-two percent. Some people project 40 million members by 1990.

As you know, I have supported your efforts fully. I have worked with this association to assure that competition can occur. I have argued that government has a role in fostering such competition for the good of the market. I have worked for increased Medicare participation in prepaid plans. I have pressed for legislation funding some efforts, guaranteeing loans for others, and relieving senseless restrictions on your work.

But I now challenge you--as the products and the beneficiaries of competition--to work with us to begin also to correct the mistakes that competition makes. If you do not do so voluntarily, the urgency of the government's needs may force us to require your help.

The problem can be stated simply. Competition in health does not take care of the poor or the disabled.

Shareholders are not urging for-profit hospitals to serve more welfare mothers. Physicians do not open practices in poor neighborhoods. Insurance companies do not make special offers to the mentally retarded or to people with AIDS.

In America, where insurance comes mostly with jobs, we must also assume that the unemployed are also badly served by competition. While some may have enough resources to pay doctor bills, almost no one without insurance can withstand a hospital stay without impoverishing themselves.

You grow because you are efficient, because you have organizational advantages for consumers, and because employers are more sophisticated than in years past.

But you also grow because you rarely deal with people who have no primary care, because you take few--if any--Medicaid patients, because the average age of your clients is low, and because your hospitals rarely deal with people who are without insurance or without jobs.

Clearly now your industry requires no Federal financial help in

competing for business. Grants and loans for HMO development and operation were once useful, but their time is past.

Indeed it is time to re-evaluate the other government aids to prepaid plans: Some say that minimum employer contributions have become artificially high payments. Others argue that the required offering of both insurance and HMO coverage is no longer necessary to assure competition. We are lobbyed by diverse groups to extend the qualification criteria to other arrangements, to expand them, or to eliminate them. Perhaps the time has come to require community service or minimal Medicaid participation for Federal qualification, for tax subsidies, and for other Federal assistance.

Please do not misunderstand me. The health care industry has benefitted from many of the innovations you have begun. The HMO legislation of years past has fostered affordable and high quality care for your members.

Let us work together as we have in the past, as a memeber of Congress I will contimue to do everything in my power to ensure that medicare and medicaid provide as much care for our vulnerable citizens as possible and I ask for your help in these legislative efforts.

You have built a reputation for solid community service as you have grown. The community needs your help now.